R.I. Refugee Health Screening Form

Please complete health screening within 30 days of U.S. arrival.
Upon completion, mail or fax to:
Refugee Health Program
Rhode Island Department of Health
3 Capitol Hill, Room 407
Providence, RI 02908
Phone: (401) 222-2901 Fax: (401) 273-4350

Provider Information
Physician's Name:
Facility:
Address:
Phone:

Patient Information		Unique ID:
Last Name:	Street Address:	Date of U.S. Arrival:
First Name:		Country of Origin:
Middle Name:		Country of Exit:
Gender: ☐ M ☐ F	City:	Language Spoken:
DOB:	County, Zip:	Language Read:
Parent/Guardian:	Phone:	Interpreter Provided: ☐Y ☐N
Ethnicity: ☐Hispanic ☐Non-Hispanic		
Race: ☐White ☐Asian ☐Native Hawaiian/ Pacific Islander ☐African American/Black ☐American Indian/Alaskan Native		
Volag (check resettlement agency): ☐International Institute of RI ☐ Jewish Family Service ☐Diocese of Providence		

Immunization Record: Review overseas medical exam (DS-2053) if available and document immunization dates. For measles, mumps, rubella, and varicella: indicate if there is lab evidence of immunity; if so, immunizations are not needed against that particular disease. For all other immunizations, update series, or begin primary series if no immunization dates are found. All vaccines may be given at the same time in different sites of the body.

Immunizations	No immunization needed if lab evidence of immunity or history of disease	Immunization Dates					
		mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy	mm/dd/yy
Measles							
Mumps							
Rubella							
Varicella (VZV)							
Diphtheria/Tetanus/Pertussis (DtaP/DTP/DT)							
Tetanus-Diphtheria (Td)							
Polio (IPV, OPV)							
Hepatitis B							
Haemophilus influenzae type b (Hib)							
Hepatitis A							
Influenza							
Pneumococcal							
Other							

Tuberculosis Screening				
PPD/Mantoux Regardless of BCG Hx		**CXR (if indicated)**		**TB Therapy (if indicated)**
Date planted		Date		☐ Referred for treatment of suspect or active TB to _____ (reportable)
Date read		Findings		☐ Referred for LTBI treatment to _____
PPD size (mm)				☐ To treat for LTBI on site
PPD interpretation	☐ Pos ☐ Neg			☐ No referral for LTBI treatment: ☐ Treated overseas ☐ Refused ☐ Pregnancy ☐ Other:
Hx of BCG?	☐Y ☐N ☐U			
Date of BCG				

-Please turn page to continue assessment-

Other Screening			
Date:	Hep B:	Date:	VDRL/RPR:
	HBsAg:		CBC with differential:
	Anti-HBs:		Hgb/Hct:
	Anti-HBc:		Blood lead (<6 yrs) venous (µg/dL):
	Hep C:		Malaria (if symptomatic):
	HIV Test: ☐ Yes ☐ No		U/A:
	O & P: *Screen for all, check respective parasite(s) if positive or* ☐ None Identified ☐ Ascaris ☐ Giardia ☐ Strongyloides Giardia Fab: ☐neg ☐pos ☐ Blastocystis ☐ H. nana ☐ Trichuris Cryptosporidium Fab: ☐neg ☐pos ☐ E. histolytica ☐ Hookworm ☐ Schistosomiasis ☐ Other: _____		
	Other: *Sickle Cell, Thalassemia, and Tay Sachs recommended based on background and physical presentation*		

Women					
LMP		Premature births		Last Pap test	
Pregnant?	☐ Y ☐ N ☐ U	Live births		Last breast exam	
# Pregnancies		Living children		Last mammogram	

Physical Exam	
Height (or length for <5yrs) (in.):	Head circumference if <5 yrs. (in.):
Weight (lbs.):	BMI (lb/in^2):
Pulse:	Blood pressure:
☐ Vision	☐ Breasts
☐ Hearing	☐ Abdomen
☐ ENT	☐ Skin
☐ Dental	☐ Male- testicular exam
☐ Lungs	☐ Female- Pap smear
☐ Lymph nodes	☐ Neurological
☐ Cardiovascular	☐ Musculoskeletal
☐ Other	

Medical History	
Allergies:	Surgery:
Current Medication:	Recent Illness in Family:
Complementary and Alternative Medicines:	Medical Problems:
Injuries/Accidents:	Childhood diseases:
History of Trauma:	Other:

Referrals	
Dental:	OB/GYN:
Hearing:	Mental Health:
Vision:	WIC:
Primary Care:	Other:

Examiner's Signature_____ **Date**_____

Examiner's Name (Printed) _____